

Annex G Consultation Questionnaire

The case for change

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

Yes No

In principle this proposal to focus on improving outcomes for older people first appears a pragmatic decision and may help to make the process more manageable by starting on an incremental basis. There is a strong argument for initial focus on improving outcomes for older people given the demographics. Arguably though it may be worth considering focusing on a smaller area that may prove more manageable in the first instance.

It should be noted that many services are not delivered with an age separation and indeed anti-age /equalities legislation that becomes law in October may challenge this approach. It may be easier to identify specific older people services in NHS but not so clear in social care services where the separation is not explicit. It will be difficult to see how budgets can practically be jointly allocated if services are identified on the basis of the age of service users when services are available to the whole population. The Scottish Government will need to consider how to realistically manage this where people receive intervention from a range of services which will not be provided on an age basis to ensure equity and improved alignment.

A one size may not fit all and the learned experience / approach that will result from applying to older people first may not be able to be applied to others exactly in the same way.

Sensible, pragmatic, local decisions to be encouraged to ensure this focus does not have an adverse, unintentional impact on outcomes for other priority groups – for example people with long term conditions, and complex needs (adults & children) and individuals at transition periods (child to adults and adult to older adult). It will be vital to ensure that services for all those who need them continue to improve also at the same time and that they are not sidelined in preference to older people priorities in relation to IA.

Outline of proposed reforms

Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

Yes No

Recommended for inclusion are housing (including adaptations), self directed support, Job Centre Plus – Dept of Work & Pensions, link to Health Works Strategy & benefits system (including SDP), Police – all which are essential to support pathways and flow plus strong partnerships with the criminal justice service.

The proposal offers a real opportunity to ensure outcomes for older people, and all service users are more effective and result in the best possible outcome. However much further detail is required on how the role of clinicians / AHPs and care professional will be strengthened as the new HSCP potentially risks weakening and diluting unique role. Strengthening of the role of clinicians, and social care professionals is welcome and will expect to see robust opportunities for therapists, including occupational therapists to inform service change and innovation. There is no explicit mention of therapists in this approach and their inclusion would drive the development of preventative and recovery / self management focussed services which enable people to maximise health outcomes and continue to live in their own homes and communities, in line with Scottish Government policies.

Occupational Therapists are one of the few staff groups to work routinely across the health and social care sector and the only Allied Health Professional to be employed in significant numbers in social work services. Occupational therapy staff contribute approximately one per cent of the social work services workforce in Scotland, yet they handle approximately 35 per cent of referrals for adult social work services. There is a constant demand for the assessments and services traditionally provided by occupational therapists, and this is likely to increase in the light of demographic change, with growing numbers of older people and people living with long-term conditions in Scotland. It is vital that the specialised role of occupational therapists is strengthened and not diluted or fragmented within the implementation of the IA by building strong leadership at every level.

A significant amount of work will be needed to identify which budgets, or proportions of budgets would be included for integration. The legislation will need to be explicit and robust to ensure that sufficient resource is included for the partnerships to function effectively. This will be particularly relevant if partnerships focus on older people first given that services will need to be maintained for all ages regardless of what is developed for older people. There may need to be significant flexibility to enable partnerships to act more widely in order to make this sustainable.

The jointly appointed, Jointly Accountable Officer will be a vital role to ensure change is delivered and that both health and social care commit to the partnerships. It will be important to ensure that the employing

organisation is not able to deflect any of the intended accountability routes. Will the partnerships become organisations employing staff such as this officer directly or will the workforce continue to be employed by separate organisations? There is evidence in existing integration projects where differences in employer expectation and support can inhibit good service integration. Secondments or transfers of staff or delegation of responsibility and staff employment from one to another will need to be considered and discussed with staff representative groups and Trade Unions.

National outcomes for adult health and social care

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Yes No

This proposal is welcome and much needed, however, still requires much further detail and fine tuning. Until it is put into action it is difficult to state with accuracy if the approach will be sufficiently robust to achieve the extent of change that will be required. In theory yes. Nationally agreed common outcomes for health and social care will enable services to work toward the same goal instead of being pulled in different directions by conflicting performance measures. One single reporting mechanism for performance reporting will significantly reduce duplication, silo working, blame culture and 'passing the buck' and should improve equity and flow for patients and ultimately the nationally agreed outcomes. The quality and scope of the outcomes will be critical. The proposed draft outcomes appear to be very appropriate and welcome the intention to replace the existing quality outcomes with these and not to retain two separate sets of outcomes.

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Yes No

Yes however these must be at a high level; otherwise we risk failure and confusing accountability & reporting mechanisms. At some stage there will need to be an explicit consideration of the potential impacts of integrated services ie where some are free at the point of delivery and others are

subject to charges and eligibility criteria. Scrutiny should be robust with clearly identified responsibility.

Governance and joint accountability

Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

Yes No

The outcomes should be unequivocal to ensure that leaders are not pulling in different directions and being overly influenced by local politics rather than evidence based national and local health and social care needs.

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Yes No

If it is deemed appropriate to achieving integration vision and objectives then yes however local decision & agreement should be reached and not centrally directed as may not work in every scenario. This offers opportunity for flexibility to ensure outcomes can be achieved in the most effective way. Specialist services may need larger populations to make them viable and this offers local or regional alternatives to meet that need. Representation for AHPs should not be lost within this process or become diluted.

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

Yes No

As well as guidance on the use of casting votes it may be valuable to develop codes of practice or guidance on a number of matters these partnerships may experience for the first time. For example, managing differences in different layers of accountability, such as between local and national government.

Recommend as an absolute minimum the inclusion of AHP & nursing leadership in addition to Clinical Director / Associate Medical Director and Chief Social Work Officer. Professional Advisors should be strengthened and should reflect integrated budget, care pathways and models of service

delivery.

Voting and non-voting members: pleased to see the inclusion of professional, service user and carer perspectives on the committee although none of these will have any voting rights. This seems a missed opportunity for driving a step change. Strongly recommend all members of the committee should have equal voting rights to prevent the committees developing a two tier hierarchy which will prevent robust decision making and risks weakening rather than strengthening professional / clinical role.

We would also suggest that partnership committees would benefit from access to a far wider range of professional advice than the Medical / Clinical Director and the Chief Social Work Officer. There needs to be access to other clinical and professional perspectives as well. In particular therapists can offer significant perspectives in relation to the community work that the partnerships will be focussed on. Creating too large a committee can be avoided by ensuring there are multi professional advisors to support the advisors attending the committee and processes to enable attendance of the most appropriate of these for relevant meetings. Excluding this rich diversity of advice will limit the capacity of the committee to understand the issues in driving community based, integrated service development.

Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Yes No

This section does not include sufficient information to give a judgement on this question however note reply in number 4 and 7 . Important not to perpetuate the dominance of Social Work / Medicine, possibly resulting in less innovation as an outcome.

Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Yes No

We welcome the scope to include all services in this, including children's services, but concerned that in the current consultation document this feels very vague to ensure any potential drive to achieve integrated children's or young people's services (physical or mental health or learning disability). The final legislation will need to ensure that while local determination of

process is possible there is a clear indication of expectations for integration and performance of all the current functions. Otherwise post code lottery may apply if the same quality standards are not applied throughout. There are different cycles of financial planning across health and social care. Local government funding is agreed in three year cycles, whereas NHS funding is annual with no carry over, whereas local authorities have more inbuilt flexibility beyond FYE. Long term financial planning to ensure stability and sustainability of services achieved will be needed and this variation may impact on budgeting and commitments.

The concerns of barriers, gaps and poor transition which have led to a drive for integration in adult services also exist in children's services, younger adults, learning disabilities and mental health. The legislation offers an opportunity to ensure the culture and ethos of working together includes all public services. There is no mention of housing, police and education services which should justifiably be included in integrated services and thus the partnerships.

Integrated budgets and resourcing

Question 10: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need "health" or "social care" support?

Yes No

Favour Option a) "Respective financial governance arrangements of each partner" though could be complex to administer but may streamline services better

The difficulty will be in the practical application of these ambitions. How health and social care organisations define exactly what is in the original budget that they will be integrating; how elements for older people versus children or adults are separated will be very complex and may be subject to protectionist behaviours in the early stages and risk lack of equity for the smaller services.

We believe that if the legislation includes a clear set of principles, based on equality and human rights this would best facilitate the achievement of the intentions of the legislation.

Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

Yes No

Yes - Intermediate Care in ECHP- Current demarcation lines & differing terms & conditions of staff including governance creates boundaries. Especially complex and time consuming for these teams are the two IT systems (daily basis) including finance required to operate within. Joint Equipment Store. Co-location of key services should be addressed with financial uplift where possible.

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Yes ? No

Once defined, the detail would enable an informal response to this question, as the document is quite rightly not prescriptive, it lacks the detail required to facilitate & enable a full response to some questions. It will offer a good starting point. The direction will need to take cognisance of other existing legislation requiring provision of specific services or duties to ensure they are not in conflict with integrated budgets. If they are, services may find it difficult to delegate budgets for services they remain independently responsible to deliver. This legislation may need to change any predecessor legislation which prevents integration.

Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

Yes ? No

Difficult to answer with so little detail. Favour corporate body option.

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes No

Employing the Accountable Officer by the host partner appears cumbersome & unnecessarily complicated. Robust governance will need to be in place.

Professionally led locality planning and commissioning of services

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Yes No

A mix of the two to ensure some standardisation across Scotland, yet ensure that local circumstances/key stakeholders are reflected and relevant to the needs / demography of locality. There should be clear overarching identification of what is to be achieved and include a requirement to fully include all professional groupings in planning and decision making including AHPs. This must require proper inclusion / decision making, not consultation after the fact. We believe there needs to be inclusion of these groups right from the earliest planning stages and with a strong voice in evaluating and proposing change. Although there are several statements of the intention to strengthen the professional voice the proposals to do this are insufficiently strong. We expect the term 'clinician' to mean a broad all-inclusive term for all professions rather than meaning a medical practitioner and as highlighted above would want to see AHP and nursing representation at the most senior level. We would expect that to be more explicit in the legislation. The process for doing this could be then left to local discretion.
All too vague to answer from informed stance.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

Yes No

The duty needs to require inclusion and decision making input of those local professionals, not just GPs this should include AHPs and nursing, not simply a duty to consult. Government monitoring visits should assess & guide to ensure local arrangements are effective and upheld.

Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

There are several possible ways for ensuring practical professional participation and advice informs planning. They include

Creating a voting seat for a Therapist on the Partnership committee
Establishing a Health Professions Forum, from which one or more representatives have a seat on the Partnership committee and locality planning groups, similar to the model used in Wales. This would be a ring fenced role with backfill / time built in rather than being undertaken on top of day job and therefore running risk of opt out or lack of time to engage fully. Placing a duty on the partnership to establish processes for accessing relevant professional advice to the partnership and to locality planning groups

Ensuring that there is opportunity for relevant professional representatives to attend the meetings where agenda items involve their expertise or services. This is the least effective as the representatives are not an integral part of discussions and can be intimidated or prevented from participating even though they are present and it is easy to assume items do not require advice which perpetuates existing practice and models as the partnership are not exposed to new innovations and opportunities for change.

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Yes No

One option, another around Social Care Sectors/Boundaries.

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

Agree contract – performance & governance. Give teeth to fulfil. Focus models of care & patient pathways.

Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

Yes No

25'000 – max 50'000 produced good results in MHS in Glasgow. Depends on Rural vs densely populated areas.

Do you have any further comments regarding the consultation proposals?

These proposals do not include housing, police, education, criminal justice service and other vital services which impact on health and wellbeing. How will these services be part of the integrated experience for service users and carers/

Occupational Therapists have a long history of working across the health and social care services in the NHS, Local Authority housing and social work departments; as well as in schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services. We welcome the opportunities to significantly improve outcomes for the people of Scotland through this legislation. There will need to be strong and clear principles explicit in the bill with a requirement to meet the national outcomes enabling partnerships success to be measured.

For patients it should improve equity, reduce duplication and offer better alignment of services resulting in better provision and cost effectiveness. It should contribute to meeting patients needs better, offering more client centre/ needs lead services where processes are simplified.

It should allow for improved partnership working with voluntary organisations and Health and Social Care services and provide better chance of seamless service (one stop shop) and more effective communication between all services. In terms of wait times this should influence shorter waiting list.

Long term financial commitment needs to be given to developing a shared information system (IT) that reduces duplication and improves efficiency and effectiveness rather than continuing with the current variety of different systems that don't speak to each other.

Do you have any comments regarding the partial EQIA? (see Annex D)

Comments

Do you have any comments regarding the partial BRIA? (see Annex E)

Comments

